date of a subsequent reconsideration decision which continues to disallow all or a portion of the disputed amount, OWCP will initiate exclusion procedures as provided by § 30.715.

(g) If the provider does not refund to the employee or credit to his or her account the amount of money paid in excess of the allowed charge, the employee should submit documentation of the attempt to obtain such refund or credit to OWCP. OWCP may authorize reasonable reimbursement to the employee after reviewing the facts and circumstances of the case.

§ 30.703 What are the time limitations on OWCP's payment of bills?

OWCP will pay providers and reimburse employees promptly for all bills received on an approved form and in a timely manner. However, no bill will be paid for expenses incurred if the bill is submitted more than one year beyond the end of the calendar year in which the expense was incurred or the service or supply was provided, or more than one year beyond the end of the calendar year in which the claim was first accepted as compensable by OWCP, whichever is later.

MEDICAL FEE SCHEDULE

§ 30.705 What services are covered by the OWCP fee schedule?

(a) Payment for medical and other health services furnished by physicians, hospitals and other providers for occupational illnesses or covered illnesses shall not exceed a maximum allowable charge for such service as determined by OWCP, except as provided in this section.

(b) The schedule of maximum allowable charges does not apply to charges for services provided in nursing homes, but it does apply to charges for treatment furnished in a nursing home by a physician or other medical professional.

(c) The schedule of maximum allowable charges also does not apply to charges for appliances, supplies, services or treatment furnished by medical facilities of the U.S. Public Health Service or the Departments of the Army, Navy, Air Force and Veterans Affairs.

§ 30.706 How are the maximum fees defined?

For professional medical services, OWCP shall maintain a schedule of maximum allowable fees for procedures performed in a given locality. The schedule shall consist of: An assignment of a value to procedures identified by HCPCS/CPT code which represents the relative skill, effort, risk and time required to perform the procedure, as compared to other procedures of the same general class; an index based on a relative value scale that considers skill, labor, overhead, malpractice insurance and other related costs; and a monetary value assignment (conversion factor) for one unit of value in each of the categories of service.

§ 30.707 How are payments for particular services calculated?

Payment for a procedure identified by a HCPCS/CPT code shall not exceed the amount derived by multiplying the relative values for that procedure by the geographic indices for services in that area and by the dollar amount assigned to one unit in that category of service.

(a) The ''locality'' which serves as a basis for the determination of average cost is defined by the Bureau of Census Metropolitan Statistical Areas. OWCP shall base the determination of the relative per capita cost of medical care in a locality using information about enrollment and medical cost per county, provided by the Centers for Medicare and Medicaid Services (CMS).

(b) OWCP shall assign the relative value units (RVUs) published by CMS to all services for which CMS has made assignments, using the most recent revision. Where there are no RVUs assigned to a procedure, OWCP may develop and assign any RVUs considered appropriate. The geographic adjustment factor shall be that designated by Geographic Practice Cost Indices for Metropolitan Statistical Areas as devised for CMS and as updated or revised by CMS from time to time. OWCP will devise conversion factors for each category of service, and in doing so may adapt CMS conversion factors as appropriate using OWCP's processing experience and internal data.

(c) For example, if the unit values for a particular surgical procedure are 2.48 for physician's work (W), 3.63 for practice expense (PE), and 0.48 for malpractice insurance (M), and the dollar value assigned to one unit in that category of service (surgery) is $61.20, then the maximum allowable charge for one performance of that procedure is the product of the three RVUs times the corresponding geographical indices for the locality times the conversion factor. If the geographic indices for the locality are 0.988(W), 0.948 (PE), and 1.174 (M), then the maximum payment calculation is:

$[(2.48)(0.988) + (3.63)(0.948) + (0.48)(1.174)] \times \$61.20$
$[2.45 + 3.44 + .56] \times \$61.20$
$6.45 \times \$61.20 = \$394.74$

§ 30.708 Does the fee schedule apply to every kind of procedure?

Where the time, effort and skill required to perform a particular procedure vary widely from one occasion to the next, OWCP may choose not to assign a relative value to that procedure. In this case the allowable charge for the procedure will be set individually based on consideration of a detailed medical report and other evidence. At its discretion, OWCP may set fees without regard to schedule limits for specially authorized consultant examinations, for directed medical examinations, and for other specially authorized services.

§ 30.709 How are payments for medicinal drugs determined?

Payment for medicinal drugs prescribed by physicians shall not exceed the amount derived by multiplying the average wholesale price of the medication by the quantity or amount provided, plus a dispensing fee.

(a) All prescription medications identified by NDC number will be assigned an average wholesale price representing the product's nationally recognized wholesale price as determined by surveys of manufacturers and wholesalers. OWCP will establish the dispensing fee.

(b) The NDC numbers, the average wholesale prices, and the dispensing fee shall be reviewed from time to time and updated as necessary.

§ 30.710 How are payments for inpatient medical services determined?

(a) OWCP will pay for inpatient medical services according to pre-determined, condition-specific rates based on the Prospective Payment System (PPS) devised by CMS (42 CFR parts 412, 413, 424, 485, and 489). Using this system, payment is derived by multiplying the diagnosis-related group (DRG) weight assigned to the hospital discharge by the provider-specific factors.

(1) All hospital discharges will be classified according to the DRGs prescribed by CMS in the form of the DRG Grouper software program. On this list, each DRG represents the average resources necessary to provide care in a case in that DRG relative to the national average of resources consumed per case.

(2) The provider-specific factors will be provided by CMS in the form of their PPS Pricer software program. The software takes into consideration the type of facility, census division, actual geographic location of the hospital, case mix cost per discharge, number of hospital beds, intern/beds ratio, operating cost to charge ratio, and other factors used by CMS to determine the specific rate for a hospital discharge under their PPS. OWCP may devise price adjustment factors as appropriate using OWCP's processing experience and internal data.

(3) OWCP will base payments to facilities excluded from CMS's PPS on consideration of detailed medical reports and other evidence.

(4) OWCP shall review the pre-determined hospital rates at least once a year, and may adjust any or all components when OWCP deems it necessary or appropriate.

(b) OWCP shall review the schedule of fees at least once a year, and may adjust the schedule or any of its components when OWCP deems it necessary or appropriate.

§ 30.711 When and how are fees reduced?

(a) OWCP shall accept a provider's designation of the code to identify a billed procedure or service if the code is consistent with medical reports and